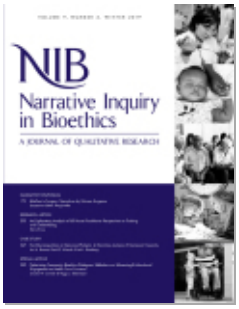
The Other

Sabha Ganai



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I struggled to learn in the environment of toxic surgical personalities. I was constantly on edge. Before long, I was anxious about every part of my job: rounding, communicating with attending surgeons and operating. I questioned my abilities and my desire to be a surgeon. I honestly hated being in the operating room, which had been my absolute favorite place to be during residency.

The unfortunate truth is that my story is not unique. The behaviors are not shocking to anyone who has interacted with a surgical trainee, and my experience is not specific to women trainees. Other surgical trainees, both men and women, have been subjected to worse treatment, longer hours, and more egregious abuse. A residency friend described her fellowship experience as "becoming her worst self."

In the end, I made it through fellowship by putting my head down, ignoring the aggression, operating in silence, and avoiding interactions that were not necessary for patient care. Ultimately, I got outstanding technical training and landed a dream job with phenomenal partners and a team-oriented approach to patient care in all areas of the hospital. But I accomplished that *in spite of* being beaten down for two years, not because of it. I could have left fellowship with exceptional training, a sense of self-worth, and a love of the operating room.

As surgeons, we must create a culture of zero-tolerance for abusive behavior in and outside of the operating room. We cannot continue to value the aggressive, arrogant alpha-male. We cannot treat technical excellence as a hall pass. No one is too good to be kind. The circle of workplace violence needs to stop with us. Accepting a toxic environment because a surgeon or group of surgeons are technically excellent is not acceptable. No one surgeon or surgical group should be considered so valuable to an institution that they are allowed to poison it from the inside.

The best surgeons I have worked with are not only technically competent, but they are also collegial and calm. They recognize the value of every person in the operating room, treat them with respect, and gain respect by instilling confidence rather than fear. They are able to manage emergencies with coordinated teamwork rather than chaos. This story is not as much about how my gender affected my training in surgery, but about my experience in a culture pickled in toxic masculinity. The 'adrenalized' vocation of surgery has allowed some surgeons to become kings and act like toddlers because they are strong, aggressive, dominant leaders.

The increasing number of women in the surgical workforce creates an opportunity to change. I believe that women bring a balance to surgery that encourages communication, holistic care, and teamwork, and our presence as leaders in the operating room, surgical administration, and resident education will force a culture change. Now that I am in the driver's seat as an attending surgeon, I vow to live by my chief resident's rules of surgery: be nice and respect others. My trainees will not only be technically excellent surgeons, they will be kind, respected for the way they treat others, and they will love being in the operating room!

The Other

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> *"From Maximus, I learned self-government, and not to be led aside by anything; and cheerfulness in all circumstances, as well as in illness; and a just admixture in the moral character of sweetness and dignity, and to do what was set before me without complaining." —Marcus Aurelius*

Surgery is an act of harm—an injury that is performed with good intentions, counting on expertise, diligence, and faith that the patient will ultimately heal with a better outcome. Critical to informed consent is establishing the doctor-patient relationship—a bond founded on trust, a trust forged through conversation, encouragement, coaching, and connection. I have given a lot of thought about what it means to fight for your patients. However, when I became a surgeon, I

never thought I would be put into a position where I would need to battle members of my own team, individuals who had never developed a relationship with my patient as an awake being. I had assumed that the surgeon had authority within her operating room, but I learned I would have to police myself, keeping a pleasant tone to appease those in the room while not backing down on maintaining standards. I will recount one lesson I learned about how surgeon mistreatment can be the sequelae of a struggle for power. This is a case of a conflict of commitment where a deliberate choice is made to impose disparate values of team members over those held within the fiduciary duty and expertise of the surgeon to honor the patient.

My dispute started with "Bob," a surgical technologist, or "scrub tech," a team member whose duty is to maintain sterility and support the surgeon with instruments, sutures, and supplies needed for the safe performance of a procedure. I was taking care of a patient with a large pelvic tumor that had a gluteal component, a sensitive threat as she literally did not recognize what she was sitting on until the outer portion grew to the size of a cantaloupe. After much discussion, we charted a course for radiation followed by resection, diversion, and reconstruction. In the operating room, I coordinated with the circulating nurses the borders of a fairly wide field to prep and then my resident and I exited the room to scrub. After gowning, I acknowledged Bob and took a few towels to start draping the perimeter of the field.

I turned around to find Bob was blocking my path, arms folded. "That is not how Dr. C drapes," he declared. I took a pause to understand what he meant, as Dr. C was a local private-practice surgeon, and while technically not one of my partners, was someone whom I respected. I replied with whatever humor I could muster, "I would hope not, I don't think he does these cases—and he's not on the consent." Bob did not budge, and I sidestepped his blockade. I mirrored his body language and crossed my arms as well. I gave him the benefit of the doubt and asked him to tell me his way of draping, which involved cutting through a paper drape, and I tried to reason, "Unfortunately, this is a sarcoma, not rectal cancer. We prepped much wider than an APR, and I do not want to contaminate the field." I held out my hand, yet Bob continued with a silent attempt at intimidation.

I thought about grabbing the drapes from a scrub tech who was hijacking my case and attempting to practice medicine, but backed down knowing I would get reported for being a belligerent 'nit-picky' female, or in gender-neutral terms, 'detail-oriented.' Instead, I sighed, "Look, this is a long case that hasn't even gotten started . . . Plastics will be operating till tomorrow if we don't . . ."

Before I had even finished my sentence, my chief resident, a man, took the drapes from Bob, and immediately handed them to me in deference. We draped, proceeded with our time-out, and started our dissection. Several scrub techs changed hands during the course of that case, but as I was in a state of flow, I let Bob go.

A few sarcomas later, I took care of a man with a 15 cm tumor near his groin, a large mass overlying his femoral vessels. We had a similar plan for radiotherapy, followed by resection and reconstruction. In advance of the procedure, I asked my plastic surgery colleague if she would be available earlier in case I needed help with nerve monitoring. I also requested a vascular tray, a set of specialized instruments, to be available. At another hospital at which I worked, I had team consistency and the vascular tray was laid open before me with every instrument displayed on a separate table. At this hospital, I was by now used to a constant battle to have the tray open and ready when I needed it because it required more time and effort for the scrub tech to count the instruments.

When I walked into the operating room, I saw Bob and spoke with him about needing the tray opened. Bob replied that it was taken care of and pointed at the tray in the corner of the room. It was there, sterile, closed, and not counted. He was not much of a conversationalist, and he implied that he was busy and would get to it. He went on to organizing other instruments, so I went on to positioning and, after readdressing the need for these instruments in our time out, proceeded with starting the operation.

The resident and I spent time tediously dissecting a margin from the tumor and slowly rolled it over, exposing branches of the femoral vessels that we meticulously tied. When I asked for a Satinsky clamp from the tray to be ready, recognizing a larger venous branch, Bob then made an unexpected excuse that the tray was intended for the Plastics portion of the case and that I couldn't have it. I sternly reiterated that I needed it and he did not respond. Around that time, Dr. P, the plastic surgeon, walked into the room to check on the timing of her portion. Unfortunately, her presence did not change the power dynamic in the room, which included me, Bob, a female resident, a female circulating nurse, and a female nurse anesthetist. As I continued dissecting, I got into a little bleeding from the vessel I meant to clamp, so I held pressure and proceeded to ask for the clamp again. Bob and I made eye contact, then he pointed to my left shoulder, which had a stray curl of hair coming from under my bouffant hat. Bob demanded that I put on a sleeve as my shoulder was contaminated. I explained to Bob that my left hand was sealing the levee, and I could not move it. Bob and I were at an unfortunate impasse.

I then turned to look straight at the nurse anesthetist who was standing behind the drapes at the head of the bed. Raising my voice, I stated, "We have a choice here between dealing with massive bleeding from this tumor versus redosing antibiotics—I want you to call your attending in—*now*!" In a moment of realization of the implications of what was going on, the clamp was immediately given to me, my finger was removed, and torrential bleeding did not happen. I immediately looked back at Bob, and without emotion said, "I'll take a sleeve for my left arm." The sleeve, of course, did not reach my left shoulder, but I diligently complied with his concern for patient safety. Bob left, flustered, for his break, and my concentration remained focused on getting that tumor out rather than getting distracted by trivial power struggles.

My resident, the female one who was assisting me, wrote a memorable faculty evaluation critiquing my conduct with Bob, suggesting that I should become more like a few of my male trauma colleagues and learn to ask for things without raising my voice. I read this in all seriousness, but then smiled at her naïveté, then laughed, because I absolutely hate raising my voice, but recognize very well that I am often not heard unless I vocalize louder, slower, and with a lower pitch. I reminded myself that at this particular hospital if I were one of my white male trauma colleagues, there would be no uncertainty that I would have a functioning team. There would be no insubordination. If they needed an instrument, they would be given it without hesitation. I have been criticized by staff for asking the residents too many questions while teaching ('she must not have known what to do'), for doing cytoreductions that last into the night ('she takes too long'), for aborting cases with unresectable tumors ('she wastes our time'), for not asking for help ('she's too stoic'), and for asking for help ('she is too needy'). Yet, for all this, I wish I simply had my orders followed without a request to do things another way.

Within the medical environment, over half of nurses have been subject to "lateral violence," a phenomenon where health care workers transform the workplace into an environment of bullying and deliberate victimization of individuals, often through subtle and repeated acts of aggression. The Institute of Medicine has taken workplace violence seriously as it has a direct link with patient safety, and the Joint Commission recognizes that in addition to newly-trained or unmarried female nurses, female physicians are often targeted in hospital settings. The bizarre notion that female surgeons could be subject to a skewed form of hierarchy in the operating room does not feel right, but is supported by data where female attending surgeons perceive less psychological safety than female surgical residents, the opposite of the finding for male surgeons who continue to grow in confidence when they become attendings.

When it came down to discussions with administration about inappropriate words and behaviors I was soon facing from numerous individuals, male and female, I was not surprised when it was dismissed as an issue with interpersonal communication. They told me I was called a "bitch," and

this was condoned as acceptable within a professional environment since I unknowingly insulted a circulating nurse by spelling out the name of an instrument I requested but they couldn't locate. The word, "bitch" of course, is a term reserved for women surgeons—we must recognize that we will be perceived as hostile when we use agentic communication, when we ask for things and give orders with the pressure of time—something surgeons are required to do in order to take care of their patients.

During my surgical residency, I did not recognize a problem with gender and surgery. I had become one of the boys, and I was proud and emboldened as I perceived myself as an equal and competitor amongst a hierarchy of brothers. It was a time when I was unable to connect with women surgeons because I did not see them, and like my resident, I judged them harshly when they were not treated with respect. Unfortunately, as we train more women and minorities to become surgeons, we still have not worked with the establishment to change a culture and system that otherwise supports discriminatory treatment directed at them and their patients. I now hold the banner high that women and minorities who become surgeons are full of grit and compassion and an ethos of excellence, and I want to hear more about their struggles and celebrate their triumphs.

Institutional culture is determined by implicit norms that drive team behavior. It is hard for any one person to dictate culture, but through influencing the process and design of teams to value diversity, inclusion, and open discussion of our vulnerabilities, we may be able to reset our collective priority back to helping patients and limit healthcare worker burnout and attrition. With great optimism, I see men and women in medicine, those individuals who honor a fiduciary duty to serve their patients, as the best-equipped professionals to regain control of institutional culture in healthcare settings, which is moving away from caring for people and closer to commanding, controlling, and profiteering. Our patients deserve better, and we deserve better.